# Med CareEast, P.A.

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## Medical History

**Please check any MEDICAL DISORDER which YOU have had or are being treated for:**

____Anemia
____Asthma
____Bleeding Disorder
____Bronchitis
____Cancer(what type)_____
____Cholesterol/Lipids
____Chronic Fatigue Syndrome
____Chronic Lung Disease
____Colitis
____Diabetes
____Diverticulitis
____Endometriosis
____Fibrocystic Breast Disease
____Fibromyalgia
____Heart Attack
____Heart Disease
____Heart Murmur
____Hepatitis
____High Blood Pressure
____HIV
____Inflammatory Bowel Disease
____Infertility
____Irritable Bowel Syndrome
____Kidney Disease
____Kidney Stone
____Leukemia
____Lupus
____Mental Disorders
____Migraines
____Osteoporosis
____Osteoarthritis
____Prostate Disease
____Seizures
____Sexual Dysfunction
____Stroke
____Thyroid Disease
____Tuberculosis
____Ulcer
____Other_____

**List any SURGERIES you have had:**

_____
_____
_____
_____

**Please list any ALLERGIES you have:**

_____
_____
_____
_____

## Social History

**Personal Habits:**

Do you use tobacco? Yes_____ No_____
If yes, in what form: Cigarettes____ Pipe____ Snuff____ Cigars____
How many packs per day?_____

Do you use alcohol? Yes_____ No_____
If yes, in what form: Wine____ Beer____ Liquor____
How many ounces/bottles per day/week?_____

Do you drink caffeinated: Coffee_____ Tea_____ Soft Drinks____
Cups, glasses or cans per day?_____

Do you exercise regularly? Yes _____ No_____
Please describe:_____